adcock

10011

MARYLAND — STATE DEPARTMETT OF HEALTH

10007

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS MD — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ANNE ARUNDEL GEN'L HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: MARYLAND — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: GLEN BURNIE X (RURAL)
STREET ADDRESS (If rural, give location): ROUTE #1 BOX 147 SOLLY ROAD

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	REEVES	ELWOOD	ADCOCK	NOV.	8	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	MAY 5 1887	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER	OWN FARM	VIRGINIA	U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	- - - - -	212-22-6731	MRS. CALDOTTY ADCOCK ROUTE 1 - BOX 147 GLEN BURNIE, MD.

3

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

434.3

Immediate cause (a) Terminal Atypical Pneumonia — 5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cardiac decompensation — 1-2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11-8, 1954, to 11-8, 1954, that I last saw the deceased alive on 11-8, 1954, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward L Beale	MD	41 Southgate Circle Annapolis	11-9-54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	Nov. 11, 1954	GLEN HAVEN	GLEN BURNIE,	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
November 10, 1954	Wm. J. Leach, Jr. Dalba. asst.	T.W. SINGLETON	GLEN BURNIE, MD

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 15 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **10012**

CERTIFICATE OF DEATH

10008

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): 10
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: USNH, Annapolis, Maryland 50

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Maryland 10
STREET ADDRESS (If rural give location): 707 Arundel Place

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) Henry (Last) ATHERTON

4. DATE OF DEATH: (Month) 11 (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W

8. DATE OF BIRTH: 3-21-79

9. AGE last birthday: 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): USN Ret

10b. KIND OF BUSINESS OR INDUSTRY: C. M. M.

11. BIRTHPLACE (State or foreign country): Ky.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased George G. Atherton

14. MOTHER'S MAIDEN NAME: Deceased Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: USNH Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

420.0
Immediate cause (a) Arteriosclerotic Heart Disease #420 — Indefinite
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0 — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-24, 19 54, to 11-8-, 19 54, that I last saw the deceased alive on 11-8-54, 19....., and that death occurred at 9:19, from the causes and on the date stated above.

R.K. MOXON — (Degree or title) LCDR MC USN — ADDRESS USNH, Annapolis, Md. — DATE SIGNED 11-8-54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 11-10-54 — NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem — LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR Nov. 9, 1954 — REGISTRAR'S SIGNATURE J. E. O'Donnell — 24. FUNERAL DIRECTOR John M. Layton Sons — ADDRESS Annapolis Md.

RECEIVED
NOV 10 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10013 4C

CERTIFICATE OF DEATH

10032

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Brooklyn Park 50
LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 111 Twelfth Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park (Balto - 25)
STREET ADDRESS (If rural, give location) 111 Twelfth Ave.

3. NAME OF DECEASED: (Type or Print) (First) Josephine (Middle) Sanders (Last) BATHON.

4. DATE OF DEATH: (Month) November (Day) 8 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: March 6, 1892

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Frederick Saunder

14. MOTHER'S MAIDEN NAME: Mary E. Real

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mary Laumann, 109 Twelfth Ave, Brooklyn Park Balto - 25, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 18 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

(260.1)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1951, to Nov 7, 1954, that I last saw the deceased alive on Nov 7, 1954, and that death occurred at 10 A.m., from the causes and on the date stated above.

SIGNATURE C. Milton Luthcum (DEGREE OR TITLE) M.D. ADDRESS Luthcum Heights Rd. DATE SIGNED Nov 8, 1954.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Nov 11, 1954

NAME OF CEMETERY OR CREMATORY New Cathedral

LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE REC'D BY LOCAL REG. 11-5-54

REGISTRAR'S SIGNATURE A. W. Hedrick Jr.

24. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hgwy.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10014

10033 CERTIFICATE OF DEATH Reg. Dist. No. .....

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Brooklyn Park 50
LENGTH OF STAY (in this place) 3yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5624 Ballman Ave. X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park 50
STREET ADDRESS (If rural give location) 5624 Ballman Ave.

3. NAME OF DECEASED: (Type or Print) (First) Etta (Middle) Beck (Last) Berry

4. DATE OF DEATH: (Month) Nov. (Day) 5 (Year) 1954

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Feb 16, 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Rudolph Beck

14. MOTHER'S MAIDEN NAME: Madeline Zink

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Franklin Berry 5624 Ballman Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Thrombosis Coronary DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death 12 hrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Coronary Thrombosis 1951

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1947, to Nov 5, 1954, that I last saw the deceased alive on Nov 5, 1954, and that death occurred at 1 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Meadelis MD 651 N Bentalou St 11-6-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF Nov 8, 1954

NAME OF CEMETERY OR CREMATORY Moreland Memorial Pk.

LOCATION (City, town, or county) (State) Baltimore Co., Md.

DATE RECD BY LOCAL REGISTRAR 11-8-54

REGISTRAR'S SIGNATURE C. W. Hedrick M

24. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hwy

M

W.C

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10016

CERTIFICATE OF DEATH

10009

Reg. Dist. No. 21

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Annapolis 10
LENGTH OF STAY (in this place) 8 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen. Hosp. 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY AACo.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (Charles Forrest)
STREET ADDRESS (If rural give location) Route # 1 Box 187

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) Vera (Last) Bolander

4. DATE OF DEATH: (Month) November (Day) 17 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F M	W	M	August 6, 1935	19 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Biller	Farm Bureau Ins.	Abbington Pennsylvania	USA

13. FATHER'S NAME: Karl H. Ziegler

14. MOTHER'S MAIDEN NAME: Thelma H. Sullivan

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
NO	NO	217-30-3426	Mr. Geo. W.F. Bolander Rt. #1 Box 187 Glen Burnie Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause 572.2	(a) Pulmonary Atelectasis due to aspiration	4 hr. ?
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Irreversable surgical shock	5 hr.
	DUE TO (c) Peritonitis due to ruptured rectal ulcer	10 hr.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death ~~but not related to the disease or condition causing death.~~	Ulcerative colitis	7 mos

19a. DATE OF OPERATION: 2 — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/9, 1954, to 11/17, 1954, that I last saw the deceased alive on 11/17, 1954, and that death occurred at 1 A.M. from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank McKinley	M.D.	Annapolis	11/18/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/20/54	Glen Haven	Glen Burnie Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
November 19, 1954	Wm J. French / L.J. Deaba mnt	R. V. Singleton,	Glen Burnie, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10034 CERTIFICATE OF DEATH

10017
Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Severn, Md. Clarks Sta
LENGTH OF STAY (in this place) 10 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 1 Box 477

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn (Rural)
STREET ADDRESS (If rural give location) Clarks Sta. Route 1 Box 477

3. NAME OF DECEASED: (Type or Print) (First) Hugo (Middle) Franz Frederick (Last) Brabandt
4. DATE OF DEATH: (Month) Nov. (Day) 21 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married
8. DATE OF BIRTH: July 7 1887
9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Machinest (Ret'd)
10b. KIND OF BUSINESS OR INDUSTRY: B.B. Crystol Co. N.Y.
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Gustave Brabandt
14. MOTHER'S MAIDEN NAME: Ida Huemme

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 141-10-4542A
17. INFORMANT & ADDRESS: Mrs. Engeline W. S. Brabandt (Severn, Md Route 1 - Box 477

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Cerebral Thrombosis DUE TO	3 weeks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Generalized Arteriosclerosis DUE TO	5 years
	(c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. ., 1954, to Nov 21., 1954 that I last saw the deceased alive on Nov 20, 1954, and that death occurred at 7 A M, from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edmund Q Merritt	M. D.	Gambrills Md	Nov 21, 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	Nov. 23 1954	Loudon Park	Baltimore, Md,

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
November 22. 1954	Clara Haehnlein L J D'Alba mgt.	T. W. Singleton,	Glen Burnie, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10018

10010 CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
LENGTH OF STAY (in this place) MARYLAND 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis,
STREET ADDRESS (If rural give location) 1106 Bayridge Rd Annapolis, Maryland

3. NAME OF DECEASED: (Type or Print) Lillian (First) Mae (Middle) BRANHAM (Last)

4. DATE OF DEATH: (Month) NOV (Day) 26 (Year) 19 54

5. SEX: F

6. COLOR OR RACE: Cauc

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 7-7-04

9. AGE last birthday 50 yr yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Ludwig

14. MOTHER'S MAIDEN NAME: Martha Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: USNH Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic rheumatic heart disease, #410 — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

ANTECEDENT CAUSE (S) DUE TO (B) disease of mitral valve,

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) stenosis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-20 , 1954., to 11-26- ..., 1954., that I last saw the deceased alive on 11-26 ..., 1954., and that death occurred at 8:45P M, from the causes and on the date stated above.

SIGNATURE James L. Hudgens Jr. M. D. ADDRESS USNH Annapolis, Md. DATE SIGNED 11-27-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF 11-29-54 | NAME OF CEMETERY OR CREMATORY Hillcrest | LOCATION (City, town, or county) (State) Annapolis Md

DATE REC'D BY LOCAL REGISTRAR Nov. 29, 1954 | REGISTRAR'S SIGNATURE H. O. Council | 24. FUNERAL DIRECTOR John M. Taylor Sons | ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **10019**

10035 # CERTIFICATE OF DEATH

Reg. Dist. No. 15

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:

COUNTY Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville X

LENGTH OF STAY (in this place) 3 mos. 3 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital 10

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore City

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City

STREET ADDRESS (If rural give location) 2226 Madison Avenue

3. NAME OF DECEASED: (Type or Print) (First) Eugene (Middle) (Last) Braxton

4. DATE OF DEATH: (Month) 11 (Day) 19 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 1/3/06

9. AGE last birthday 48 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter

10B. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Undetermined

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Undetermined

14. MOTHER'S MAIDEN NAME: Ella Braxton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO: Lung Tuberculosis — Known to us since 8/16/54

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) DUE TO:

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/16, 19 54, to 11/19, 19 54 that I last saw the deceased alive on 11/19, 19 54, and that death occurred at 4:15p M, from the causes and on the date stated above.

SIGNATURE AND TITLE OF PERSON CERTIFYING: L. Benedict M. D.

ADDRESS: Crownsville, Md.

DATE SIGNED: 11/19/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: 11/27/54

NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.

LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE REC'D BY LOCAL REGISTRAR: November 27, 1954

REGISTRAR'S SIGNATURE: R. W

24A. FUNERAL DIRECTOR: Curtis A. Williams

ADDRESS: 3232 W Lanvale St

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10020

10036 CERTIFICATE OF DEATH Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
COUNTY Anne Arundel County MARYLAND Md.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel County
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel County
STREET ADDRESS (If rural give location) Riggs Ave. Severna Park

3. NAME OF DECEASED: (Type or Print) (First) Barbara (Middle) Brockmeyer (Last)

4. DATE OF DEATH: (Month) Nov. (Day) 25 (Year) 1954

5. SEX F.

6. COLOR OR RACE? W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles M. Ulrich

14. MOTHER'S MAIDEN NAME: Barbara Rose Ulrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS. Mr. Brockmeyer Riggs Ave.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Shock + Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

ANTECEDENT CAUSE (S) DUE TO (B) Infarction of left kidney — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) arteriosclerosis — yr.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Left hemiplegia — 6 wks

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/25/, 1954 to 11/25/, 1954 that I last saw the deceased alive on 11/25/, 1954, and that death occurred at 1:35 P.M., from the causes and on the date stated above.

SIGNATURE Frank M. Hurley M.D. ADDRESS M.D. Annapolis, DATE SIGNED 11/25/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF 11/29/54 — NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery — LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REGISTRAR: November 27, 1954 — REGISTRAR'S SIGNATURE: R. W

24. FUNERAL DIRECTOR: Charles F. Dill — ADDRESS: 1516 E. Fort Ave.

10021

MARYLAND 10011

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnapolis
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS 116 Spa View Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 116 Spa View Ave.

3. NAME OF DECEASED (Type or Print) (First) ANNIE (Middle) W (Last) BROWN

4. DATE OF DEATH (Month) NOVEMBER (Day) 19 (Year) 19 54

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 29, 1877

9. AGE last birthday 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Francis G. Stehle

14. MOTHER'S MAIDEN NAME August Spies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----

(If year, give war or dates of service) ----

16. SOCIAL SECURITY NO. ----

17. INFORMANT AND ADDRESS Mrs. Malcolm Waring- Daughter- same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Left Hemiplegia

(c) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: (a) 10 days; (b) years; (c) years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 17, 19 54, to Nov 19, 19 54, that I last saw the deceased alive on Nov 19, 19 54, and that death occurred at 7 A.M., from the causes and on the date stated above.

SIGNATURE George L. Basil (Degree or title) M.D. ADDRESS Annapolis Md. DATE SIGNED 11-2

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 11-22-54 NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. Nov. 22, 1954 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

10037 10022

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN RURAL
LENGTH OF STAY (in this place) 1-yr 3-Mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY ANNE ARUNDEL
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN FRANKLIN MANOR
STREET ADDRESS (If rural, give location) EXETER STREET

3. NAME OF DECEASED: (First) CHARLES (Middle) C. (Last) [illegible] SR.
(Type or Print)

4. DATE OF DEATH (Month) [illegible] (Day) [illegible] (Year) 19[illegible]

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	White	MARRIED	11-24-1898	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Special police	U.S. Gov.	WILKES BARRE. PA	U.S.A.

13. FATHER'S NAME: Adam C. Butterbaugh

14. MOTHER'S MAIDEN NAME: MARY E. MYERS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
		M. ALMA BUTTERBAUGH — FRANKLIN MANOR MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	[illegible]	
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	[illegible]	
	DUE TO		
	(c)	[illegible]	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [illegible] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒ DATE SIGNED 11-13-54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 16-1954	Cedar Hill Cemetery	Suitland Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	M. FUNERAL DIRECTOR	ADDRESS
11-13-54	Elsie Viet Williams	Simmons Bros.	1061 good hope Rd SE Wash DC

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10023

10012 CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-54

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 26 Southgate Avenue

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) T (Last) CHURCH

4. DATE OF DEATH: (Month) 11 (Day) 14 (Year) 1954

5. SEX: M

6. COLOR OR RACE: Cauc

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M

8. DATE OF BIRTH: 4-6-82

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USN Ret

10B. KIND OF BUSINESS OR INDUSTRY: Navy

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Forrister

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Barry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I & II

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: USNH Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Rupture Dissecting Aneurysm of Aorta #451 — INTERVAL BETWEEN ONSET AND DEATH: Indef.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work [ ] Not while at work [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-11, 1954, to 11-14, 1954, that I last saw the deceased alive on 11-14 1954, and that death occurred at 10 AM, from the causes and on the date stated above.

SIGNATURE R. K. MOXON LCDR USN M.D. ADDRESS USNH, ANNAPOLIS, MD. DATE SIGNED 11-15-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 11-16-54 — NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery — LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REGISTRAR Nov. 16, 1954 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Ben L. Hopping and Son — ADDRESS Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10024

10038

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 5,6,7, FilmG173 11-23-54 ot

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberstone, Md
LENGTH OF STAY (in this place) 71 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Y

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Charles (Middle) Forrest (Last) Colhoun

4. DATE OF DEATH: (Month) November (Day) 9 (Year) 1954

5. SEX Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: July 1 1883

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10B. KIND OF BUSINESS OR INDUSTRY: Tobacco - wheat

11. BIRTHPLACE (State or foreign country): Fox Neck, Cumberstone Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Murray Colhoun

14. MOTHER'S MAIDEN NAME: Cornelia Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Miss Adelaide F Colhoun,

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) coronary occlusion

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO coronary artery disease

(C) generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-9-, 1954, to 11-9-, 1954, that I last saw the deceased alive on 11-9-, 1954, and that death occurred at 8:30 M, from the causes and on the date stated above.

SIGNATURE Emily H. Wilson, M.D. ADDRESS Lothian, Md. DATE SIGNED 11-9-54.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | DATE THEREOF Nov. 10, 1954 | NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | LOCATION (City, town, or county) (State) Suitland, Md

DATE REC'D BY LOCAL REGISTRAR 11-10-54 | REGISTRAR'S SIGNATURE Elsie West Williams | 24. FUNERAL DIRECTOR T A Hardesty & Son | ADDRESS Galesville Md

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10025

10039 CERTIFICATE OF DEATH Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville X
LENGTH OF STAY (in this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Calvert
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Republic
STREET ADDRESS (If rural) give location) None listed ✓

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) Francis (Last) Commodore
4. DATE OF DEATH: (Month) 11 (Day) 1 (Year) 19 54
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow
8. DATE OF BIRTH: 2/14/76
9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: — — — —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Pulmonary Tuberculosis — Known to us since 10/21/54

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis — Known to us since 10/14/54

19A. DATE OF OPERATION: — — — 19B. MAJOR FINDINGS OF OPERATION — — — — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — M. 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ 21F. HOW DID INJURY OCCUR? — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/14, 19 54 to 11/1, 1954, that I last saw the deceased alive on 11/1, 19 54, and that death occurred at 2:15pM, from the causes and on the date stated above.

SIGNATURE Stephen E. Kramer M. D. ADDRESS Crownsville, Md. DATE SIGNED 11/1/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF 11-4 54 | NAME OF CEMETERY OR CREMATORY Browns | LOCATION (City, town, or county) Port Republic (State) Md

DATE REC'D BY LOCAL REGISTRAR 11-2-54 | REGISTRAR'S SIGNATURE H. M. Joe

24 FUNERAL DIRECTOR P. F. Sowell ADDRESS Prince Frederick, Md

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10026

10040 CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RIVIERA BEACH
LENGTH OF STAY (in this place) 8 YRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS RIVIERA DRIVE & LAUREL ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVIERA BEACH
STREET ADDRESS (If rural give location) RIVIERA DRIVE & LAUREL ROAD

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) GERTRUDE (Last) CONLEY

4. DATE OF DEATH: (Month) NOV. (Day) 26 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: JAN. 25, 1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM J. RICHARDS

14. MOTHER'S MAIDEN NAME: ANN CLINTON

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 217 14 3666

17. INFORMANT & ADDRESS: HUSBAND - CARROLL F. CONLEY - SAME

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ..... Carcinoma Cervix — Interval Between Onset And Death: 2 years.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE — 10 years

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JUNE, 19 51, to NOV. 26, 19 54, that I last saw the deceased alive on NOV. 25 19 54, and that death occurred at 5:02 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
J. Brady Smith M.D. RIVIERA BEACH MD. 11/26/54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial Nov. 29, 1954 New Cathedral Balto Maryland

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR ADDRESS
November 30, 1954 L. J. D'Alba Geo J. Jones 4001 Ritchie Highway Balto 21 Md

RECEIVED
DEC 1 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10027

10013

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Item 8, Film 0174, 12/10/54 Ed

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel | STATE Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2 Water St.

2. USUAL RESIDENCE (HOME) OF DECEASED: COUNTY A.A. | STATE Maryland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 20 Water St.

3. NAME OF DECEASED (Type or Print): (First) Laura (Middle) Virginia (Last) Curry

4. DATE OF DEATH: (Month) 11 (Day) 18 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 4-15-[illegible]23

9. AGE last birthday: 31 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier

10b. KIND OF BUSINESS OR INDUSTRY: Soda Drug Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William E. Curry

14. MOTHER'S MAIDEN NAME: Mamie Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-22-1742

17. INFORMANT AND ADDRESS: Anne Wright - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension and Cardiovascular Disease

(c)

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ✓, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE [signature] (Degree or Title) MD ADDRESS [illegible] DATE SIGNED 11/19/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF [illegible] | NAME OF CEMETERY OR CREMATORY [illegible] | LOCATION (City, town, or county) [illegible] (State)

DATE REC'D BY LOCAL REG. Nov. 20, 1954 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR [illegible] | ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND

STATE DEPARTMENT OF HEALTH

10028

10014 CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY A. A. | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10 | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Ft. Camp Meade

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Michael (Last) Dickenson

4. DATE OF DEATH: (Month) 11 (Day) 20 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 11-18-54

9. AGE last birthday: yrs. | If under 1 year: Months. Days 2 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James W. Dickenson

14. MOTHER'S MAIDEN NAME: Virginia Otey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS: Jas W. Dickenson (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Edema and Anoxia, a secondary to — Interval Between Onset and Death: at Birth

Antecedent cause(s) — Placenta Insufficiency —

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c) Atelectasis of Newborn — Birth

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/18, 1954, to 11/20, 1954, that I last saw the deceased alive on 11/19, 1954, and that death occurred at 5:20 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Philip Price M.D. | ADDRESS 95 Clay St. Annapolis | DATE SIGNED 11/20/54

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE 11-22-54 | NAME OF CEMETERY OR CREMATORY Hillcrest Cemt | LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Nov. 21, 1954 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John W. Layton Sons | ADDRESS Annapolis Md

10X+2713?2

MARYLAND STATE DEPARTMENT OF HEALTH

10041

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10029

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY [illegible] MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]; LENGTH OF STAY (in this place) [illegible]; HOSPITAL OR INSTITUTION OR STREET ADDRESS Hanover Rd X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]; STREET ADDRESS (If rural, give location) [illegible]

3. NAME OF DECEASED (Type or Print): (First) [illegible] (Middle) [illegible] (Last) [illegible]

4. DATE OF DEATH: (Month) [illegible] (Day) 13 (Year) 1954

5. SEX [illegible]

6. COLOR OR RACE [illegible]

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) [illegible]

8. DATE OF BIRTH [illegible]

9. AGE last birthday 74 yrs. If under 1 year: Months [illegible] Days [illegible]; If under 24 hrs.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]

10b. KIND OF BUSINESS OR INDUSTRY [illegible]

11. BIRTHPLACE (State or foreign country) [illegible]

12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME [illegible]

14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]

16. SOCIAL SECURITY NO. [illegible]

17. INFORMANT AND ADDRESS [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1954

Immediate cause (a) Cancer of the Liver — Interval Between Onset and Death [illegible]

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) [illegible] — [illegible]

(c) [illegible] — [illegible]

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. [illegible]

19a. DATE OF OPERATION [illegible] 1941

19b. MAJOR FINDINGS OF OPERATION Cancer

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) [illegible]

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY [illegible] (CITY OR TOWN) [illegible] (COUNTY) [illegible] (STATE) [illegible]

TIME OF INJURY (Month) [illegible] (Day) [illegible] (Year) [illegible] (Hour) [illegible] m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? [illegible]

22. I hereby certify that I attended the deceased from 1951, 19[illegible] to Nov 13 1954 that I last saw the deceased alive on Nov 14 1954 and that death occurred at 12 X m., from the causes and on the date stated above.

SIGNATURE [illegible] (Degree or title) [illegible] ADDRESS [illegible] DATE SIGNED 11/15/54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	Nov. 18, 1954	FRIENDSHIP	A. A. County	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
November 17, 1954	Miss Clara Hasley L. J. D'Alba. mar.	W. Dingleton	Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10030

CERTIFICATE OF DEATH

10042

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item if information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Severn
LENGTH OF STAY (in this place) 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Annapolis Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Severn
STREET ADDRESS (If rural, give location) Old Annapolis Road

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) JOSEPH (Last) DOODY

4. DATE OF DEATH: (Month) November (Day) 3 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Seperated

8. DATE OF BIRTH: March 13 1891

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Balto City Fire dept.

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Doody

14. MOTHER'S MAIDEN NAME: Elizabeth Scanlon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Alice M. Doody Old Annapolis Rd. Severn, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cardiac Decompensation — Interval between onset and death: 3 years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO (b) Arteriosclerotic H-V Disease
DUE TO (c) Arteriosclerosis, General

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November, 1954, to Nov. 3, 1954, that I last saw the deceased alive on Nov 2, 1954, and that death occurred at 6 P.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Bobby L. Jones M.D. Linthicum Hgts. Glen Burnie Md 11/5/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 11/6/54 — NAME OF CEMETERY OR CREMATORY New Cathedral Cem. — LOCATION (City, town, or county) (State) 4300 Old Frederick Rd.

DATE REC'D BY LOCAL REG. 11-4-54 — REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR John J. Cowen & Son — ADDRESS 90 Hollins

2K

MARYLAND STATE DEPARTMENT OF HEALTH

10043

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10031

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and complete answering of questions is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Curtis Bay
LENGTH OF STAY (In this place) Lifetime.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Curtis Bay Yard. K

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural, give location) Marley Neck Rd.

3. NAME OF DECEASED (Type or Print): (First) Harold (Middle) Lucius (Last) Dykes
4. DATE OF DEATH: (Month) 11 (Day) 9 (Year) 54 19

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 12/20/19
9. AGE last birthday: 34 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sergeant First Class. U.S. Army
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Loyd Creek, Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harrell L. Dykes
14. MOTHER'S MAIDEN NAME: Fannie Hall.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY No.:
17. INFORMANT AND ADDRESS: Mrs. H. L. Dykes, wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion. — Interval Between Onset and Death: Hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH:
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour): m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE: Medical Examiner (Degree or title) ADDRESS: Local Examiner, Glen Burnie, Md. DATE SIGNED: 11-9-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 11-12-54
NAME OF CEMETERY OR CREMATORY: Holy Cross
LOCATION (City, town, or county) (State): Md.

DATE REC'D BY LOCAL REGISTRAR: 11-11-54
REGISTRAR'S SIGNATURE: M. W. Hedrick
24. FUNERAL DIRECTOR: Jas. L. McCurdy
ADDRESS: 130 E. Fort Ave.

10032

MARYLAND 10015

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

tem 8, FilmG173 11-15-54 et

1. PLACE OF DEATH: COUNTY A A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Seneca

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Londonmore
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Kenneth (Middle) E. (Last) Egan

4. DATE OF DEATH: (Month) 11 (Day) 5 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married

8. DATE OF BIRTH: 11-5-54

9. AGE last birthday: 40 yrs. — If under 1 year: Months. Days. — If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Customer relations

10b. KIND OF BUSINESS OR INDUSTRY: Public relation

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: George E. Egan

14. MOTHER'S MAIDEN NAME: Katherine Sandrock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT AND ADDRESS: Dorothy C. Egan Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary edema, acute — Interval between onset and death: 1 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Parathyroid Adenoma — 1 month?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED White at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-1- ., 1954, to 11-5 ., 1954, that I last saw the deceased alive on 11-5- ., 1954, and that death occurred at 2:55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) John R. Martin M.D. ADDRESS Annapolis, Md. DATE SIGNED 11-6-54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 11-8-54 NAME OF CEMETERY OR CREMATORY Hillcrest Cem LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Nov. 7, 1954 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John M Layton Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10033

10044 **CERTIFICATE OF DEATH**

Reg. Dist. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marley Cook
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Queen Ann Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Marley Cook
STREET ADDRESS (If rural, give location) 17 Queen Ann Rd

3. NAME OF DECEASED: (Type or Print) (First) BERTHA (Middle) (Last) ELLIOTT

4. DATE OF DEATH: (Month) November (Day) 1 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

8. DATE OF BIRTH: Sept. 14-1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: (own home)

11. BIRTHPLACE (State or foreign country): Roanoke City Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Bonneville

14. MOTHER'S MAIDEN NAME: Isabel Webster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: Louis P. Elliott - Marley Park, Glen Burnie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Cerebral Thrombosis DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Arteriosclerosis, general DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: / 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-7-1 19 49, to 11-1 19 54, that I last saw the deceased alive on 10-29 19 54, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Bobby L. Jones MD 5 Central Ave Sd. Glen Burnie Md 11/1/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Nov. 3-1954

NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery

LOCATION (City, town, or county) (State) Glen Burnie, Md.

DATE REC'D BY LOCAL REG. November 3, 1954

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS R. V. Singleton - Glen Burnie

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10034

10045 CERTIFICATE OF DEATH Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville X
LENGTH OF STAY (In this place) 2yrs. 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 510 N. Arlington Avenue

3. NAME OF DECEASED: (Type or Print) (First) Louise (Middle) (Last) Flowers

4. DATE OF DEATH: (Month) 11 (Day) 14 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 2/13/91

9. AGE last birthday 63 yrs. IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: — — —

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Chestnut

14. MOTHER'S MAIDEN NAME: Ardella Trusdale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO. — — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary edema

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO Generalized arteriosclerosis

(C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — —

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — —

22. I hereby certify that I attended the deceased from 11/13, 19 52 to 11/14, 19 54 that I last saw the deceased alive on 11/14, 19 54, and that death occurred at 10:00 a.m. from the causes and on the date stated above.

SIGNATURE L. Benedict, M. D. M.D.
ADDRESS Crownsville, Md.
DATE SIGNED 11/15/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 11/19/54
NAME OF CEMETERY OR CREMATORY Mt Auburn Cem
LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REGISTRAR 11-19-54
REGISTRAR'S SIGNATURE G. W. Hedrick Jr.
24 FUNERAL DIRECTOR Mrs Katie R Williams
ADDRESS 3224 Sehwerdt St

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V.S. A15 — 10-53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10035

10016 CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
COUNTY A A. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis R
LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: A. A. General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Tracys MD
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) MARY (Middle) [illegible] (Last) FRANCIS FORD
4. DATE OF DEATH: (Month) Nov (Day) 30 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widow	Dec 9 1874	79 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wetwell, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Frank Whittington
14. MOTHER'S MAIDEN NAME: Sara Jane Chaney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Mary Frances Ford, Tracys Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
420 !
IMMEDIATE CAUSE (A) Coronary occlusion
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Coronary artery disease
DUE TO
(C) generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: None.
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 19 54 to Nov 30, 19 54 that I last saw the deceased alive on Nov. 29, 1954, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

SIGNATURE Emily H. Wilson, M.D. ADDRESS Littleton, Md. DATE SIGNED 12-1-54.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Dec 2 1954
NAME OF CEMETERY OR CREMATORY St James
LOCATION (City, town, or county) (State) Tracys Md

DATE REC'D BY LOCAL REGISTRAR Dec. 1, 1954
REGISTRAR'S SIGNATURE W. D. French
24. FUNERAL DIRECTOR Funeral Home Galvanized ADDRESS

10036

MARYLAND — **STATE DEPARTMETT OF HEALTH**

10017 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arurdel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: rural
STREET ADDRESS (If rural, give location): Gambrills

3. NAME OF DECEASED (Type or Print): (First) OCIE (Middle) F (Last) FORE

4. DATE OF DEATH: (Month) November (Day) 11, (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 31, 1916

9. AGE last birthday: 38 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Leck, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Fields

14. MOTHER'S MAIDEN NAME: Alephair Flemmings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY No.: 234-32-9839

17. INFORMANT AND ADDRESS: Werbin F. Fore Husband same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Ac. Rheuming Rheumatic Fever — Interval Between Onset and Death: 6 Wks.

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Rheumatic Heart Disease — 20 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemorrhage from Bladder, Cause unknown — 4-5 Wks.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/8, 19 54, to 11/11, 19 54 that I last saw the deceased alive on 11/10, 19 54, and that death occurred at 6:05 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Harriet K Lemmon MD — ADDRESS: Annapolis, Md — DATE SIGNED: 11/11/54

23. BURIAL, CREMATION REMOVAL (Specify): Removal — DATE: Nov 11 1954 — NAME OF CEMETERY OR CREMATORY: To — LOCATION (City, town, or county) (State): Clintwood, Dickerson Co., Va.

DATE REC'D BY LOCAL REG.: Nov. 11, 1954 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: Ben L. HOPPING AND SON — ADDRESS: Annapolis, Maryland

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

10037

10046

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton | LENGTH OF STAY (In this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Franklin (Last)
4. DATE OF DEATH: (Month) Nov. (Day) 11 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Widowed	?	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Nutwell Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Hiram Franklin
14. MOTHER'S MAIDEN NAME: Mary A. Weems

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Molly Dorsey, Churchton Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial infarction

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart disease.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X, Inquiry ___ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes X, accident ___, suicide ___, homicide ___, undetermined ___.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Bruce Lewis Grant M.D. — Shady Side Md. — 11-14-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 15-1954	Woodfield	Galesville Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR — ADDRESS
11-15-54	Elsie Mae Wilkins	T. A. Heard Duty & Son, Galesville Md

MARYLAND STATE DEPARTMENT OF HEALTH

10038

10047 **CERTIFICATE OF DEATH**

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

Ite 3,Film 173 11-12-4 et

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: p[illegible] write the [illegible]uses of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie — LENGTH OF STAY (In this place) 14 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Glen Burnie.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Central Avenue	STREET ADDRESS (If rural, give location) 407 Central Ave.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Harry		Geis	November	4,	1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Widower	Oct. 3, 1868	85 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Car Clerk (Retired)	Lumber yard	Brooklyn, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Geis	Mary Stoll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
O	None	407 Central Ave., Mrs. Frank W. Bennett Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐X Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave K. Paulsen M.D.	Deputy Medical Examiner.	Glen Burnie, Md.	II/6/54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 6, 1954	Cedar Hill	Brooklyn, (RURAL) Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
November 6 1954	L. J. D'Alba	T.W.Singleton	Glen Burnie, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10039

10048 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE X
LENGTH OF STAY (in this place) 12 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS home 318-6th Ave. N.E.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
STREET ADDRESS (If rural give location) Same 318-6th Ave N.E.

3. NAME OF DECEASED: (Type or Print) (First) LYDIA (Middle) none (Last) GILBERT

4. DATE OF DEATH: (Month) NOV. (Day) 4 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	W	Widowed	6 MAY 1880	74 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	none	England	yes - USA

13. FATHER'S NAME: William Templeman (dec.)

14. MOTHER'S MAIDEN NAME: Eliza Plummer (dec.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	none	Son: Edmund T. Gilbert - Same address

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
Immediate cause	(a) Uremia	6 weeks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Chronic nephritis	2 yrs
	(c) DUE TO Chronic myocarditis	5 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right hemiplegia - 3 previous strokes — 1 yr

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
none				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
none			m.		

22. I hereby certify that I attended the deceased from Feb. ,1954, to present, 19..., that I last saw the deceased alive on Nov. 4, 1954, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Hubert F. Manuyak	M.D.	901 Edgely Rd. Glen Burnie, Md.	11-4-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	11-8-54	London Park	Baltimore	Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
(Nov 9, 1954) November 9, 1954	L J D'Alba	John M. Layton Sons	Annapolis Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08
54
1954

MARYLAND

STATE DEPARTMENT OF HEALTH

10018 10040

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 8, FilmG173 11-29-54 et

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place): 79
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Homewood Convl. Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 198 Prince George Street

3. NAME OF DECEASED (Type or Print): (First) JESSIE (Middle) DELIA (Last) GILES

4. DATE OF DEATH: (Month) NOVEMBER (Day) 13 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Aug. 7, 1875

9. AGE last birthday: 79 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Baldwnsville, N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Rodgers

14. MOTHER'S MAIDEN NAME: Joswphine Russell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ---
(If year, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT AND ADDRESS: RADML. Donald T. Giles- Son - same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arterio Sclerotic Heart Disease — Interval Between Onset and Death: Unknown

Antecedent cause(s)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) Generalized Arterio Sclerosis — Interval Between Onset and Death: Unknown
(c) — Interval Between Onset and Death: Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Paralysis Agitans — Interval Between Onset and Death: Unknown

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY:
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1954, to Nov 13, 1954, that I last saw the deceased alive on Nov 13, 1954, and that death occurred at 1 PM m., from the causes and on the date stated above.

SIGNATURE: George C. Bosie (Degree or title) M.D. ADDRESS: Annapolis Md DATE SIGNED: 11-14-54

23. BURIAL, CREMATION, REMOVAL (Specify): Removal
DATE: 11-16-54
NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
LOCATION (City, town, or county) (State): Syracuse, Onondaga Co. N.Y.

DATE REC'D BY LOCAL REG.: Nov. 14, 1954
REGISTRAR'S SIGNATURE: J. T. O'Connell

24. FUNERAL DIRECTOR: Ben L. Hopping and Son ADDRESS: Annapolis, Md.

MARGIN RESERVED FOR BINDING

10041

MARYLAND — STATE DEPARTMENT OF HEALTH

Dr Martin

10019 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 10	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. General 00	STREET ADDRESS (If rural, give location) 1133 Munroe St

3. NAME OF DECEASED (Type or Print)	(First) Fred	(Middle)	(Last) Griffie	4. DATE OF DEATH	(Month) 11	(Day) 8	(Year) 1954
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Divorced)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours / Min.
Male	White		12-9-1875	79 yrs.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist	10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Fred Griffie		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Manuel Griffie Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
15 Immediate cause	(a) Carcinomatosis	1 wk
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Cecum	6 months
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11-5-, 1954, to 11-8-, 1954, that I last saw the deceased alive on 11-8-, 1954, and that death occurred at 1:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
James A. Straton M.D.	Annapolis Md	11/11/54

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	11-11-54	Hillcrest Cemt	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 11, 1954	[signature]	John M Taylor Sons	Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH

10049 **CERTIFICATE OF DEATH** 10042

FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

Lyons 5.6.FilmG174 12-2-54 et

1. PLACE OF DEATH — COUNTY: a. a. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sudley — LENGTH OF STAY (in this place): 1 week — HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: a. a. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Sudley — STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Pearl (Middle) Anne (Last) Gross

4. DATE OF DEATH: (Month) Nov (Day) 16 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: April 26, 1546 mo.

9. AGE last birthday: yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore County

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Gross

14. MOTHER'S MAIDEN NAME: Mary Gross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY No.: —

17. INFORMANT AND ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pneumonia — Interval between onset and death: 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: /

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: Bourie Linn Gray (Degree or title) M.D. — ADDRESS: Sudley Md. — DATE SIGNED: 11.16.54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Nov 18, 54 — NAME OF CEMETERY OR CREMATORY: Adams Cem — LOCATION (City, town, or county) (State): Baltimore Md

DATE REC'D BY LOCAL REG. Nov. 18-54 — REGISTRAR'S SIGNATURE: J. B Dent

24. FUNERAL DIRECTOR: Hardesty Funeral Home — ADDRESS: Sykesville

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10020 **CERTIFICATE OF DEATH** Reg. Dist. No. 10043 ....

1. PLACE OF DEATH:
COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1005 West St. Annapolis, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY AA
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
STREET ADDRESS (If rural give location) 1005 West St. Annapolis, Md.

3. NAME OF DECEASED: (Type or Print) (First) Harold (Middle) Leo (Last) HANNON

4. DATE OF DEATH: (Month) November (Day) 8 (Year) 1954

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): M

8. DATE OF BIRTH: 4-11-94

9. AGE last birthday 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): USN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mass

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Deceased Lawrence J Hannon

14. MOTHER'S MAIDEN NAME: Deceased Ann Whalen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: USNH, Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4 420.1
IMMEDIATE CAUSE (A) Sclerosis Coronary Artery #420.1

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(260X) (C)

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes Mellitus

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-19 ..., 1954, to 9-15 ..., 1954, that I last saw the deceased alive on 10-26 ....., 1954., and that death occurred at 9:50 M, from the causes and on the date stated above.

SIGNATURE [signature] LCDR MC USN M. D. ADDRESS U.S.N.H. Annapolis, Md. DATE SIGNED 11- 8-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF 11-10-54 NAME OF CEMETERY OR CREMATORY St Mary's Cemt LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REGISTRAR Nov. 9, 1954 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 10 1954
BUREAU V. S.

MARYLAND

STATE DEPARTMENT OF HEALTH

10044

10021 CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Gen. Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Josephine (Middle) Calloway (Last) Harrison
4. DATE OF DEATH: (Month) 11 (Day) 4 (Year) 1954

5. SEX: Fe
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)
8. DATE OF BIRTH: Sept 13 1878
9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): A.A. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Cadle
14. MOTHER'S MAIDEN NAME: Zora Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yr., give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: John Calloway Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cerebral Hemmhage unit	8 hrs.
Antecedent cause(s)	(b) Left hemiplegia	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Artio Sclerotic Heart Disease	3 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Hyper tension	3 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-4 1AM, 1954, to 11-4 5 P.M., 1954, that I last saw the deceased alive on 11-4, 1954, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George C Beal M.D. ADDRESS Annapolis Md DATE SIGNED 11-6-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 11-7-54 NAME OF CEMETERY OR CREMATORY Hall Crest LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Nov. 7, 1954
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10045

10050 CERTIFICATE OF DEATH Reg. Dist. No. ....

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (First) Vergie (Middle) (Last) Haynes
4. DATE OF DEATH: (Month) 11 (Day) 25 (Year) 19 54

5. SEX	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH.	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Negro	Separated	1896	58 yrs.				

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Robert Preston
14. MOTHER'S MAIDEN NAME: Lizzie Preston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) Unk.
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Cerebral Vascular Accident	Known to us since 10/25/54
ANTECEDENT CAUSE (S)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) Hypertensive arteriosclerotic cardio-	Undetermined
	DUE TO vascular disease	
	(C)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION. - - - -
19B. MAJOR FINDINGS OF OPERATION - - - - -
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY - - - - -
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - - - - - -
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY - - - - - M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? - - - - - -

22. I hereby certify that I attended the deceased from 10/25, 19 54 to 11/25, 19 54, that I last saw the deceased alive on 11/25, 19 54 and that death occurred at 11:35 P.M., from the causes and on the date stated above.

SIGNATURE C. E. Stubah M. D. M. D.
ADDRESS Crownsville, Md.
DATE SIGNED 11/26/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov 30/54	Balto Nat. Cemetery	Balto	Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-29-54	C. H. Hedrick Jr.	Va. Brooks Ruggold	1463 P. Carey

VS. A15 — 10 - 53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10046

MARYLAND

STATE DEPARTMETT OF HEALTH

10022

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place) MARYLAND — HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Confederate Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md / — STREET ADDRESS (If rural, give location) 19 Eastern Ave

3. NAME OF DECEASED (Type or Print): (First) Marguerite (Middle) L. (Last) Hopkins

4. DATE OF DEATH: (Month) 11 (Day) 29 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: 12-31-1895

9. AGE last birthday: 59 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Teaching

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY: U. S.

13. FATHER'S NAME: Joshua Linthicum

14. MOTHER'S MAIDEN NAME: Eliza C. White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Ernest Linthicum Silver Spring Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Carcinomatosis with

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malnutrition

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) Several (b) Months (c) Several Months

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteri Sclerosis Moderate

19a. DATE OF OPERATION: April 1954

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach (Gastrectomy)

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

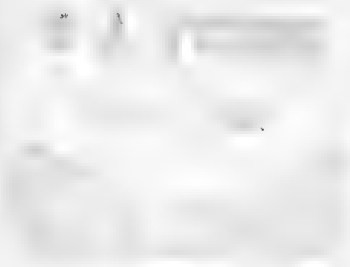
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1954, to Nov 29, 1954, that I last saw the deceased alive on Nov 29, 1954, and that death occurred at 8 P. m., from the causes and on the date stated above.

SIGNATURE: George E Basil (Degree or title) M D — ADDRESS: Annapolis Md — DATE SIGNED: 11-30-54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) — DATE: 12-2-54 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff — LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: Dec 1, 1954 — REGISTRAR'S SIGNATURE: [illegible] French — 24. FUNERAL DIRECTOR: John M. Taylor Sons — ADDRESS: Annapolis Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10047

10051 CERTIFICATE OF DEATH Reg. Dist. No. . . .

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riviera Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenwood and Creek Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riviera Beach
STREET ADDRESS (If rural give location) Glenwood and Creek Rd.

3. NAME OF DECEASED: (Type or Print) (First) FREDERICK (Middle) H. (Last) HUMMER

4. DATE OF DEATH: (Month) Nov. (Day) 2, (Year) 19 54

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: July 2, 1890

9. AGE last birthday: 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): foreman

10b. KIND OF BUSINESS OR INDUSTRY: Gas & Electric Co

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Hummer

14. MOTHER'S MAIDEN NAME: Elizabeth Selhein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-0[illegible]-7251

17. INFORMANT & ADDRESS: Riviera, Beach, Md. Mrs. Euth Hummer - Glen[illegible]od & Creek Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Coronary Thrombosis — Interval Between Onset And Death: 30 minutes

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Coronary insufficiency — 1 year
DUE TO (c) Hypertension — 5 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 30, 1953, to Nov. 2, 1954, that I last saw the deceased alive on Nov. 2, 1954, and that death occurred at 11:20 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Randall M. McLaughlin M.D. ADDRESS Pasadena. Md. DATE SIGNED Nov. 2, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 11/6/54 | NAME OF CEMETERY OR CREMATORY Woodlawn Cem. | LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR 11-5-54 | REGISTRAR'S SIGNATURE A. R. Hedrick | 24. FUNERAL DIRECTOR Wm. J. Dickman & Sons | ADDRESS Balto 17 Md.

VS. A15

10048

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10052

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights
LENGTH OF STAY (in this place) 28 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 96 Fairview Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Heights, Md.
STREET ADDRESS (If rural, give location) Box 96, Fairview Ave.

3. NAME OF DECEASED: (Type or Print) (First) Ella (Middle) (Last) Johnson

4. DATE OF DEATH: (Month) (Day) (Year) November 14 1954.

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 18, 1875

9. AGE last birthday: 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Peter Oliver

14. MOTHER'S MAIDEN NAME: Pauline Benway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Fam. Inf. - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Cereval vascular hemorrhage	4 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Hypertension	5 yrs +
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 6, 1954, to Nov 14, 1954, that I last saw the deceased alive on Nov 12, 1954, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE C. Milton Linthicum — (DEGREE OR TITLE) M.D. — ADDRESS Linthicum Heights Md. — DATE SIGNED 11/14/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 11/17/54 — NAME OF CEMETERY OR CREMATORY Holy Cross — LOCATION (City, town, or county) Balto. (State)

DATE REC'D BY LOCAL REG. 11-15-54 — REGISTRAR'S SIGNATURE G. W. Hedrick

24. FUNERAL DIRECTOR Jas. R. Lemmon — ADDRESS 130 E. Fort Ave

MARYLAND

10049

STATE DEPARTMETT OF HEALTH

10023 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY A a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
MARYLAND
LENGTH OF STAY (in this place) 16
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis / Md
STREET ADDRESS (If rural, give location) 31 N. Glenn Ave

3. NAME OF DECEASED (Type or Print) (First) Ursula (Middle) Nancy (Last) Jones

4. DATE OF DEATH (Month) 11 (Day) 17 (Year) 19 54

5. SEX F | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 12-24-1902 | 9. AGE last birthday 51 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Geo. R. Gilbreath
14. MOTHER'S MAIDEN NAME Laura Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Louis J. Jones (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) coronary occlusion	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) coronary heartdisease	3 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-14 ., 19 54, to Dr. Albert Anderson ., 19 ., that I last saw the deceased alive on 11-17 ., 19 ., and that death occurred at 8 10 A m., from the causes and on the date stated above. 11-18-54

SIGNATURE Edith Bodler (Degree or title) M.D. ADDRESS 45 Franklin St Annapolis Md DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 11-19-54 | NAME OF CEMETERY OR CREMATORY St Mary's | LOCATION (City, town, or county) Annapolis | (State) Md

DATE REC'D BY LOCAL REG. Nov. 19, 1954
REGISTRAR'S SIGNATURE J. O. Council
24. FUNERAL DIRECTOR John W. Layton Sons ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

MARYLAND

10024

STATE DEPARTMETT OF HEALTH 10050

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place) — MARYLAND — HOSPITAL OR INSTITUTION OR STREET ADDRESS 901 Cedar Park Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A. — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — STREET ADDRESS (If rural, give location) 901 Cedar Park Rd.

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) J. (Last) LEVAY

4. DATE OF DEATH: (Month) 11 (Day) 27 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~, (Specify)

8. DATE OF BIRTH: 3/3/75

9. AGE last birthday: 79 yrs. — If under 1 year: Months. Days. — If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Merchant Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Retail Shoes

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Michael Levay

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs Anna T. Levay (D)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arterio Sclerotic Heart Disease — Interval Between Onset and Death: Unknown

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arterio Sclerosis — Interval Between Onset and Death: years

(c) Complete right Inguinal Hernia — Interval Between Onset and Death: 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☒ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1954, to Nov 27, 1954, that I last saw the deceased alive on Nov 27, 1954, and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): George C. Baird M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 11-28-54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): — DATE: 11-30-54 — NAME OF CEMETERY OR CREMATORY: GLEN HAVEN — LOCATION (City, town, or county) (State): GLEN BURNIE MD.

DATE REC'D BY LOCAL REG.: Nov. 29, 1954 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: John M. Taylor Son — ADDRESS:

MARGIN RESERVED FOR BINDING

RECEIVED
DEC 1 1
BUREAU V. S.

10051

MARYLAND — STATE DEPARTMENT OF HEALTH

10053

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park X
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Linstead X

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
STREET ADDRESS (If rural, give location): Linstead

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Lorant

4. DATE OF DEATH: (Month) 11 (Day) 2 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE, MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 12-30-1877

9. AGE last birthday: 76 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Lenk

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: Mrs. Carl Same as Above

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Cardio. Vascular Renal — Interval Between Onset and Death: 1 year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): — (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — (CITY OR TOWN): — (COUNTY): — (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): No m. — INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept., 1954, to Nov. 1, 1954, that I last saw the deceased alive on Nov. 1, 1954, and that death occurred at 3 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): James S. Billingsley M.D — ADDRESS: 108 Central Ave. Glen Burnie Md — DATE SIGNED: Nov 2, 1954

23. BURIAL / ~~CREMATION~~ / ~~REMOVAL~~ (Specify) — DATE: 11-4-1954 — NAME OF CEMETERY OR CREMATORY: Holy Redeemer — LOCATION (City, town, or county): Baltimore (State): Md.

DATE REC'D BY LOCAL REG.: Nov. 4, 1954 — REGISTRAR'S SIGNATURE: L J DeAlba

24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor & Sons Annapolis, Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10054 CERTIFICATE OF DEATH

09973

Reg. Dist. No. 2 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY A.A Co. MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Rural
LENGTH OF STAY (in this place) 12 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marshner Rd. Lake Shore

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) Lake Shore AA Co. Md.

3. NAME OF DECEASED: (Type or Print) (First) Otto (Middle) John (Last) Marshner

4. DATE OF DEATH: (Month) 11 (Day) 20 (Year) 1954

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: AUG. 23, 1878

9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): TAILOR, RETIRED

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME: Paul Marshner

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: LOUIS J. MARSHNER, MARSHNER RD. LAKESHORE, A.A. CO., MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebrovascular accident — Interval Between Onset And Death: 5 min

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease — years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gastrointestinal virus infection (Probable)

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1954, to November, 1954, that I last saw the deceased alive on Nov 20, 1954, and that death occurred at 8:30 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. F. Gahrmann M.D. Mountain Rd, Pasadena Md 11/20/54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

DATE THEREOF 11/23/54

NAME OF CEMETERY OR CREMATORY Schwartz

LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REGISTRAR 11-22-54

REGISTRAR'S SIGNATURE H. L. Hedrick

24. FUNERAL DIRECTOR C.F. Hoffmann ADDRESS 2219 LAKE AVE. (13)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10052

10055 **CERTIFICATE OF DEATH** Reg. Dist. No. 24

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore County
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex
STREET ADDRESS (If rural give location) Box 366

3. NAME OF DECEASED: (Type or Print) (First) Lovett (Middle) (Last) Martin

4. DATE OF DEATH: (Month) 11 (Day) 22 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 7/3/14

9. AGE last birthday: 40 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY: — — — — —

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry Martin

14. MOTHER'S MAIDEN NAME: Louisanne Sample

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Brain Syndrome associated with

ANTECEDENT CAUSE (B) DUE TO Central Nervous System Syhpilis (Meningo-encephalitis)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO

INTERVAL BETWEEN ONSET AND DEATH: 7 days

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — — — — — —

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — —

22. I hereby certify that I attended the deceased from 11/15, 19 54 to 11/22, 19 54, that I last saw the deceased alive on 11/22, 19 54, and that death occurred at 7:30p M, from the causes and on the date stated above.

SIGNATURE Stanley C. Sargent M. D. ADDRESS Crownsville, Md. DATE SIGNED 11/23/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) 11-27-54 DATE THEREOF 11-27-54 NAME OF CEMETERY OR CREMATORY Mt. Auburn LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REGISTRAR 11-27-54 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Geo. G. [illegible] ADDRESS 1303 Westwood

RECEIVED
DEC - 1
FILED AT V. S.

10056 MARYLAND STATE DEPARTMENT OF HEALTH 10053

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

Items 8, 9 + 10c - Film G-173 11/22/54

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena — LENGTH OF STAY (In this place) 20 y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mountain Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same
STREET ADDRESS (If rural, give location) Same.

3. NAME OF DECEASED (Type or Print): (First) George Burnett (Middle) Missel (Last)

4. DATE OF DEATH (Month) (Day) (Year): Nov 6-1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 5/31/~~1~~14

9. AGE last birthday: 40 ~~39~~ yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gasoline Station Attendant. (owner)

10b. KIND OF BUSINESS OR INDUSTRY: Insurance Claims Manager Phoenix Mutual

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Harry Missel

14. MOTHER'S MAIDEN NAME: Ruby Temple

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 221-07-5153

17. INFORMANT AND ADDRESS: Mrs. C. B. Missel

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Self inflicted wounds through brain, chest wall. — Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Laceration of left wrist.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY home | (CITY OR TOWN) Pacadena, Md. | (COUNTY) A.A. | (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): 11/6/54 1 P. m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Shot himself with a rifle.

22 *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Gustine Fowler Dod Deputy Medical Examiner. Glen Burnie, Md. 11/8/54

DISPOSITION REMOVAL (Specify): Burial | DATE THEREOF 11/9/54 | NAME OF CEMETERY OR CREMATORY Glen Haven | LOCATION (City, town, or county) Glen Burnie | (State) Md.

DATE REC'D BY LOCAL REG.: November 9 1954 | REGISTRAR'S SIGNATURE: Z J D'Alba | 24. FUNERAL DIRECTOR: R. V. Singleton | ADDRESS: Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1 A

MARYLAND

10025

10054

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS. | LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS ANNE ARUNDEL GEN'L HOSP

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MINNIE (Middle) (Last) MOORE

4. DATE OF DEATH (Month) NOV. (Day) 7 (Year) 1954

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW.

8. DATE OF BIRTH APRIL 28 1883

9. AGE last birthday 71 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME

11. BIRTHPLACE (State or foreign country) ROBINSON, A.A.Co. MD

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME GEORGE UTTERBINE

14. MOTHER'S MAIDEN NAME LAURA DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If year, give war or dates of service)

16. SOCIAL SECURITY No. NONE

17. INFORMANT AND ADDRESS MRS. LAURA L. SAUNDERS MISSION ST. PASADENA, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) [illegible]

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) [illegible]

(c)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOV. 5, 1954, to NOV. 7, 1954, that I last saw the deceased alive on NOV. 7, 1954, and that death occurred at 12:28 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Leonard A. Beck M.D. 4 Saulsbury Pl. Pa. NOV 8 54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | DATE NOV. 10, 1954 | NAME OF CEMETERY OR CREMATORY GLEN HAVEN CEM. | LOCATION (City, town, or county) GLEN BURNIE, MD (State)

DATE REC'D BY LOCAL REG. NOVEMBER 9, 1954 | REGISTRAR'S SIGNATURE Wm. J. French L. J. D'Alba mnt.

24. FUNERAL DIRECTOR T. W. SINGLETON, ADDRESS GLEN BURNIE, MD

MARGIN RESERVED FOR BINDING

1954

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10055

10057

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Anne Arundel — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 42yrs.5mos.19days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Harford
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown
STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED: (First) Hosea (Middle) (Last) Morgan

4. DATE OF DEATH: (Month) 11 (Day) 27 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 1872?

9. AGE last birthday: 82? yrs. IF UNDER 1 YEAR, Months — Days — IF UNDER 24 HRS., Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: — — — —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO. — — —

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: Known to us since 2/12/51

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Generalized and Cerebral Arteriosclerosis

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychosis with Mental Deficiency — Known to us since 6/8/12

19A. DATE OF OPERATION: — — — —

19B. MAJOR FINDINGS OF OPERATION — — — — — — — — — —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) — — — —

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — — — M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? — — — — — — — —

22. I hereby certify that I attended the deceased from 1/21, 19 48 to 11/27, 19 54 that I last saw the deceased alive on 11/27, 19 54, and that death occurred at 12Noon from the causes and on the date stated above.

SIGNATURE L. Benedict, M. D. ADDRESS Crownsville, Md. DATE SIGNED 11/27/54

M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR: November 30, 1954

REGISTRAR'S SIGNATURE: Katherine M. Joyce

24. FUNERAL DIRECTOR & ADDRESS:

RECEIVED
DEC
BUREAU OF S

10056

MARYLAND

10026

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 78 Conduit St.

3. NAME OF DECEASED (Type or Print): (First) Arthur (Middle) Dorsey (Last) Moss
4. DATE OF DEATH: (Month) 11 (Day) 18 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED: Married
8. DATE OF BIRTH: 1-9-1884
9. AGE last birthday: 70 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life. Not "retired"): Ist Supt. Post Office
10b. KIND OF BUSINESS OR INDUSTRY: Post office
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: George W. Moss
14. MOTHER'S MAIDEN NAME: Mary Parkinson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS: Bessie B. Moss (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a). Acute Pulmonary Edema — Minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b). Arteriosclerotic Cardio-Vascular Disease — yrs.

(c).

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT (Specify) SUICIDE HOMICIDE | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10, 1954, to Nov 18, 1954, that I last saw the deceased alive on Nov 15, 1954, and that death occurred at 1.30 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Annie K Emmons M.D. | ADDRESS Annapolis Md. | DATE SIGNED 11/18/54

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 11-20-54 | NAME OF CEMETERY OR CREMATORY St Pauls Church Yard | LOCATION (City, town, or county) Baden (State) Md.

DATE REC'D BY LOCAL REG. Nov 19, 1954 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR John M Tayloe Sons | ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

10057

10058 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer to each question is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Cattlesburg MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis md. LENGTH OF STAY (In this place) Few minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS Naval Hospital Road.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Not made.
STREET ADDRESS (If rural, give location) 1000 Headquarters Company.

3. NAME OF DECEASED (Type or Print): (First) Keith (Middle) Vance (Last) Paul
4. DATE OF DEATH (Month) Nov. (Day) 17 (Year) 1954

5. SEX: F. 6. COLOR OR RACE: C. 7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) Single 8. DATE OF BIRTH: 10/30/34 9. AGE last birthday: 20 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Army (Pvt.) 10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Lexington - Kentucky 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Lemoni James Paul.
14. MOTHER'S MAIDEN NAME: Augusta Vaught.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) 16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Fort Meade Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Fracture of skull. — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Annapolis St. Rd. (CITY OR TOWN) Annapolis St. (COUNTY) A. A. (STATE) Md.
TIME OF INJURY Month: 11 Day: 17 Year: 1954 Hour: 11:00 P.M. INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY occur? Pedestrian vs. automobile accident

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Wm. Cook Funeral Dir. Funeral Director Glen Burnie, Md. 11/18/54.

MAY CREMATION BE MADE? (Yes or No) Burial | DATE THEREOF 21 Nov 54 | NAME OF CEMETERY OR CREMATORY unknown | LOCATION (City, town, or county) Corinth | (State) Kentucky

DATE RECD BY LOCAL REG. 18 Nov 54 | REGISTRAR'S SIGNATURE T.A. Cordo, CWO, USA | 24. FUNERAL DIRECTOR ADDRESS WM. COOK, BALTO., MD.

Mrs. Clara Hastings.

MARYLAND STATE DEPARTMENT OF HEALTH

10058 91

10059

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

USE WRITING FLUID ONLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glen Burnie — LENGTH OF STAY (in this place): 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 203 Phelps Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Same — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Same
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Douglas (Middle) John (Last) Perry

4. DATE OF DEATH (Month) (Day) (Year): II-6-54 19

5. SEX: M.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 7/18/54

9. AGE last birthday: yrs. If under 1 year: Months 3 Days 19 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leon Perry

14. MOTHER'S MAIDEN NAME: Jeanne Frank

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Dr. Leon Perry, (Father)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Suffocation — Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Home — (CITY OR TOWN): Glen Burnie, Md. — (COUNTY): A.A. — (STATE):

TIME OF INJUR (Month) (Day) (Year) (Hour): II/6/54 8 A. m. — INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Baby was entangled in bed linens.

22. *I certify that I took charge of the remains described above, held an Autopsy ___, Inspection X, Inquiry X thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ___, accident X, suicide ___, homicide ___, undetermined ___.*

SIGNATURE: Seymour H Pumphrey — (Degree or title): Deputy Medical Examiner — ADDRESS: Glen Burnie, Md. — DATE SIGNED: II/6/54

BURIAL CREMATION MOVAL (Specify): Burial — DATE THEREOF: Nov 8 1954 — NAME OF CEMETERY OR CREMATORY: Glen Haven — LOCATION (City, town, or county) (State): Glen Burnie Md

DATE REC'D BY LOCAL REG.: November 8, 1954 — REGISTRAR'S SIGNATURE: Dr Alba — 24. FUNERAL DIRECTOR: Hopping & Kirkley — ADDRESS: Glen Burnie Md.

VS. A15A

10059

10060

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
   COUNTY: Anne Arundel
   CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): Fort George G Meade
   LENGTH OF STAY (in this place): 1 year
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
   STATE: Ohio
   COUNTY: Hamilton
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Kenton
   STREET ADDRESS (If rural give location): 340 W. Columbus

3. NAME OF DECEASED: (First) Pfeiffer (Middle) (Baby Girl) (Last)

4. DATE OF DEATH: (Month) November (Day) 17 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 16 Nov 54

9. AGE last birthday: yrs.
   IF UNDER 1 YEAR: Months 1 Days
   IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bernard Carmen Pfeiffer

14. MOTHER'S MAIDEN NAME: Mary Margaret Hobble

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
    (If Yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Bernard Pfeiffer

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity — Interval Between Onset And Death: 1 day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 16 Nov, 1954, to 17 Nov, 1954, that I last saw the deceased alive on 17 Nov, 1954, and that death occurred at 1700, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Ardinger m.d. JOSEPH F ARDINGER MD Fort Meade 17 Nov 54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 19 Nov 54
NAME OF CEMETERY OR CREMATORY: Post Cemetery
LOCATION (City, town, or county) (State): Fort Meade Md

DATE REC'D BY LOCAL REGISTRAR: 18 Nov 54
REGISTRAR'S SIGNATURE: T. A. GORDON, CWO, USA

24. FUNERAL DIRECTOR: Chaplain Wilson
ADDRESS: Fort Meade

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10060

10061 CERTIFICATE OF DEATH Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville X; MARYLAND LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Sans Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Anne Arundel; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md; STREET ADDRESS (If rural give location) 215 Chesapeake Ave

3. NAME OF DECEASED: (Type or Print) (First) Edwin (Middle) Hall (Last) Pierce

4. DATE OF DEATH: (Month) 11 (Day) 6 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 12-25-1869

9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Musician

10b. KIND OF BUSINESS OR INDUSTRY: Musician

11. BIRTHPLACE (State or foreign country): Auburn N Y

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Dr James Pierce

14. MOTHER'S MAIDEN NAME: Frances Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Minnie W. Pierce (2)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 3 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized Arteriosclerosis — 10 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1954, to Nov 6, 1954, that I last saw the deceased alive on Nov 5, 1954, and that death occurred at 3:15 PM from the causes and on the date stated above.

SIGNATURE E. G. Merritt (Degree or title) M.D ADDRESS Cambridge Md DATE SIGNED 11-7-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 11-8-54 NAME OF CEMETERY OR CREMATORY Auburn N Y LOCATION (City, town, or county) Auburn (State) N Y

DATE REC'D BY LOCAL REGISTRAR Nov 9, 1954 REGISTRAR'S SIGNATURE R M [illegible]

24. FUNERAL DIRECTOR John W. Sayler Sons ADDRESS Annapolis Md

VS. A15

10061

MARYLAND — **STATE DEPARTMETT OF HEALTH**

10027

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 13 Monument St

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): 13 Monument St.

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) S. (Last) Pinkney

4. DATE OF DEATH: (Month) 11 (Day) 30 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.

8. DATE OF BIRTH: 3-5-1897

9. AGE last birthday: 57 yrs. — If under 1 year: Months | Days — If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Willie Shaw

14. MOTHER'S MAIDEN NAME: [illegible] Smothers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: James Pinkney - Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of liver — Interval between onset and death: 5 Months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cirhosis of liver

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 13, 1954, to Nov 30, 1954, that I last saw the deceased alive on Nov 30, 1954, and that death occurred at 6:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or Title): [illegible] M.D. — ADDRESS: 110 - Clay St. Annapolis, Md. — DATE SIGNED: 12/3/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 12-4-54 — NAME OF CEMETERY OR CREMATORY: Bellevue Nat'l — LOCATION (City, town, or county): Annapolis, Md. (State)

DATE REC'D BY LOCAL REG.: Dec. 5, 1954 — REGISTRAR'S SIGNATURE: [illegible] O'Donnell

24. FUNERAL DIRECTOR: [illegible] — ADDRESS: 108 E. Washington St. Annapolis, Md.

BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10062

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH
   COUNTY: A.A. Co
   CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
   LENGTH OF STAY (in this place): MARYLAND
   HOSPITAL OR INSTITUTION OR STREET ADDRESS: Y13 Hilltop Rd

2. USUAL RESIDENCE (HOME) OF DECEASED
   STATE: Md. COUNTY: A.A.
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn
   STREET ADDRESS (If rural give location): Y13 Hilltop Rd.

3. NAME OF DECEASED: (First) Mark (Middle) Pomory (Last)

4. DATE OF DEATH: (Month) (Day) (Year): 11. 17 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH: 12. 7. 75

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker

10B. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Hungary

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis

14. MOTHER'S MAIDEN NAME: Sophie Bogdonus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Family - Same

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE
(A) Carcinoma of lung — about 1 yr.

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
(B) DUE TO Carcinoma of prostate (Prostatectomy March 18, 1953.)
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ———

19A. DATE OF OPERATION: ———

19B. MAJOR FINDINGS OF OPERATION ———

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ———

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) ———

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ——— M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR? ———

22. I hereby certify that I attended the deceased from July 4, 1954, to Nov. 17, 1954 that I last saw the deceased alive on Nov. 17, 1954, and that death occurred at 11:30 A M, from the causes and on the date stated above.

SIGNATURE: Hyman G. Myers M.D. ADDRESS: 516 Cathedral St. DATE SIGNED: Nov. 18, 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY): B | DATE THEREOF: 11/20/54 | NAME OF CEMETERY OR CREMATORY: Glen Haven | LOCATION (City, town, or county) (State): Balto.

DATE REC'D BY LOCAL REGISTRAR: 11-19-54 | REGISTRAR'S SIGNATURE: G. W. Pedrick JR

24. FUNERAL DIRECTOR: Jos. L. Lucas ADDRESS: 30 E. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10063

10063 CERTIFICATE OF DEATH

Reg. Dist. No. .

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Lombardee Beach X R#1 Glen Burnie Box 242
LENGTH OF STAY (in this place) 17 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. Anne Arundel COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lombardee Beach R#1 Glen Burnie Box 242
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) Edwin (Last) Schmidt

4. DATE OF DEATH: (Month) November (Day) 1 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 2/7/1891

9. AGE (last birthday): 63 yrs. IF UNDER 1 YEAR: Months 9 Days 25 IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired) Cashier

10b. KIND OF BUSINESS OR INDUSTRY: Garage

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Albert Edwin Schmidt Sr.

14. MOTHER'S MAIDEN NAME: Emma Virginia Yoe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 214-14-4253

17. INFORMANT & ADDRESS: Mary Elizabeth Schmidt - wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 24 hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Hypertension — 5 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 19, 1952, to Nov. 1, 1954, that I last saw the deceased alive on Nov. 1, 1954, and that death occurred at 3:20 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
C. M. McLaughlin M.D. Pasadena Md. Nov. 1, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 11.1.54 NAME OF CEMETERY OR CREMATORY Lorraine LOCATION (City, town, or county) Bal Co. (State)

DATE REC'D BY LOCAL REGISTRAR 11/2/54 REGISTRAR'S SIGNATURE C. W. Hedrick JE

24. FUNERAL DIRECTOR Jas. L. McCurley ADDRESS 130 E. Fort Ave.

MARYLAND STATE DEPARTMENT OF HEALTH

10064

10064

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Shore Acres X

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural, give location) Shore Acres

3. NAME OF DECEASED (Type or Print) (First) MARGARET (Middle) (Last) SEBOUR

4. DATE OF DEATH (Month) (Day) (Year) Nov. 6. 1954

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH June. 26. 1877

9. AGE last birthday 77 yrs. If under 1 year Months / Days; If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Long

14. MOTHER'S MAIDEN NAME Elizabeth Weis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Capt. John Sebour - Shore Acres.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Glomerular Nephritis.

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) ? (b) 1.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 29, 1954, to Nov 1, 1954, that I last saw the deceased alive on Nov. 1, 1954, and that death occurred at 4:15 A m., from the causes and on the date stated above.

SIGNATURE T. Brideet Tuxedo, M.D. (Degree or title) ADDRESS Arnold, Md. DATE SIGNED Nov. 8, 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE Nov. 1954

NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery

LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REG. 11-9-54

REGISTRAR'S SIGNATURE A. L. Hedrick M.D.

24. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS. INC. Baltimore Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 100658

10065 CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. X
LENGTH OF STAY (in this place) 24 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md.
STREET ADDRESS (If rural give location) 702 Franklin Street ✓

3. NAME OF DECEASED. (Type or Print) (First) Rudolph (Middle) (Last) Snowden

4. DATE OF DEATH: (Month) 11 (Day) 10 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): separated
8. DATE OF BIRTH: 1878
9. AGE last birthday 76 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Orderly in hospital
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Snowden
14. MOTHER'S MAIDEN NAME: Eliza Rainer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT & ADDRESS. Crownsville State Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis
ANTECEDENT CAUSE (B) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized Arteriosclerosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY ——— M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

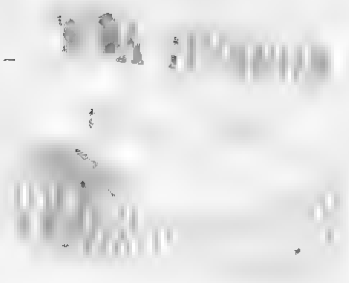
22. I hereby certify that I attended the deceased from 4/23/30 19 , to 11/10 , 19 54 that I last saw the deceased alive on 11/10 , 19 54, and that death occurred at 8:10 a M., from the causes and on the date stated above.

SIGNATURE [signature] M. D. ADDRESS Crownsville, Md. DATE SIGNED 11/10/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) with burial permit
DATE THEREOF 11/14/54
NAME OF CEMETERY OR CREMATORY University Memorial
LOCATION (City, town, or county) (State) Hanover, Md.

DATE REC'D BY LOCAL REGISTRAR November 17, 1954
REGISTRAR'S SIGNATURE Katherine M. Joyce
24. FUNERAL DIRECTOR [illegible]
ADDRESS [illegible]

V.S. A15—10-53



MARYLAND STATE DEPARTMENT OF HEALTH 10066

10066

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 7-2

MARGIN RESERVED FOR BINDING

USE WRITE OR PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie — LENGTH OF STAY (In this place) Few weeks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Baltimore-Annapolis Blvd. Marley Park-Bridge. X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1802 Division Ave

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Stanley (Last)

4. DATE OF DEATH: (Month) Nov. (Day) 21 (Year) 1954

5. SEX: M. | 6. COLOR OR RACE: Colored. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower. | 8. DATE OF BIRTH: 2/14/1911 | 9. AGE last birthday: 43 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Aiken, Md. | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Stanley | 14. MOTHER'S MAIDEN NAME: Virgie Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: Steven Stanley (Brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fracture of skull - of both legs below knee.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture of both femurs. - Internal injuries

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT, SUICIDE, HOMICIDE? PROBABLE CAUSE WAS PRIMARY X OR CONTRIBUTING CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Balt. Annapolis Blvd. | (CITY OR TOWN) Glen Burnie | (COUNTY) A. A. | (STATE) Md.

TIME OF INJURY (Month) 11/21/54 (Day) (Year) (Hour) 2A. m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? automobile hit rail of bridge

22 I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE: Conrad H. Pankrantz | (Degree or title) Deputy Medical Examiner | ADDRESS Glen Burnie, Md. | DATE SIGNED 11-21-54

BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 11-26-54 | NAME OF CEMETERY OR CREMATORY Mt Calvary Cem. | LOCATION (City, town, or county) Brooklyn Md (State)

DATE REC'D BY LOCAL REG. 11-26-54 | REGISTRAR'S SIGNATURE 9:2m. Hedrick JK | 24. FUNERAL DIRECTOR Elmer O. Wilson | ADDRESS 1000 Bentley

VS. AIRA

10067

MARYLAND

10067

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) William (Middle) P. (Last) Starlings

4. DATE OF DEATH (Month) 11 (Day) 9 (Year) 1954

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. Widower

8. DATE OF BIRTH 10-7-1878

9. AGE last birthday 76 yrs.
If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grade Operator Ret.

10b. KIND OF BUSINESS OR INDUSTRY A.A. Co Roads

11. BIRTHPLACE (State or foreign country) Calvert Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS Mrs J. W. Moreland Edgewater Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Heart Disease — Interval between onset and death: Several years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Arteriosclerosis — Interval between onset and death: Several years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1954, to Nov 8, 1954, that I last saw the deceased alive on Nov 8, 1954, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE Rufus C Bassett (Degree or title) M D ADDRESS Annapolis Md DATE SIGNED 11-8-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 11-12-54 NAME OF CEMETERY OR CREMATORY All Hallows Cemt LOCATION (City, town, or county) Birdsville (State) Md

DATE REC'D BY LOCAL REG. Nov. 12, 1954

REGISTRAR'S SIGNATURE Edward Collinson

24. FUNERAL DIRECTOR John W. Taylor & Son ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10068

10068 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey | LENGTH OF STAY (in this place) Few Minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Route #8

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Warrenton
STREET ADDRESS (If rural, give location) Field Station 860I A.A.U.

3. NAME OF DECEASED (Type or Print): (First) Rodney (Middle) Robert (Last) Steele
4. DATE OF DEATH (Month) (Day) (Year): Nov. 7-1954

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: I/8/3I
9. AGE last birthday: 23 yrs. If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): In the U.S.Army
10b. KIND OF BUSINESS OR INDUSTRY: Army.
11. BIRTHPLACE (State or foreign country): Weymouth,Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James F.Steele
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes
16. SOCIAL SECURITY No.:
17. INFORMANT AND ADDRESS: U.S.Army Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Fracture of skull,fracture of neck,

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) and fracture of bony structure of the

(c) face. Sudden

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. TYPICAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY State Route #8 | (CITY OR TOWN) Dorsey | (COUNTY) A.A. | (STATE) Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY II/7/54 I2.I0 P.M. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Automobile Collision.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Deputy Medical Examiner. Glen Burnie Md. II/7/54

CREMATION (Signify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Unknown | Weymouth Cemetery | Boston So., Mass.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS

M. COOK, INC., BALTO., MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10069

10069 **CERTIFICATE OF DEATH** Reg. Dist. No. 28

1. PLACE OF DEATH:
COUNTY Ann Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 1 mo. 16 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~Baltimore~~
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 922 N. Broadway

3. NAME OF DECEASED: (Type or Print) (First) Della (Middle) -- - (Last) Sterling
4. DATE OF DEATH: (Month) Nov. (Day) 6 (Year) 1954
5. SEX: Fem.
6. COLOR OR RACE: Negro.
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed
8. DATE OF BIRTH August 31 1886
9. AGE last birthday: 68 yrs | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (State or foreign country): Arrundle Co. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Parker
14. MOTHER'S MAIDEN NAME: Agnes Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X
IMMEDIATE CAUSE (A) Chronic myocarditis
ANTECEDENT CAUSE (S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Hypertensive cardio-vascular disease
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH: Known to us since admission (9-20-54).

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Generalized arteriosclerosis

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: - - - -
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) - - -
21C WHERE DID INJURY OCCUR? (City or town) (County) (State) - - -
21D TIME OF INJURY (Month) (Day) (Year) (Hour) - - - M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? - - -

22. I hereby certify that I attended the deceased from 9-20, 19 54 to 11-6, 19 54 that I last saw the deceased alive on 11-5, 19 54, and that death occurred at 6:10 AM, from the causes and on the date stated above.
SIGNATURE Stephen E. Kramer M.D. ADDRESS Crownsville, Md. DATE SIGNED 11-6-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 11/11/54
NAME OF CEMETERY OR CREMATORY Mt Calvery Cem
LOCATION (City, town, or county) (State) Brooklyn Md.
DATE REC'D BY LOCAL REGISTRAR 11-12-54
REGISTRAR'S SIGNATURE A W Hedrick
FUNERAL DIRECTOR Elroy O. Wilson
ADDRESS 1100 Bl[illegible] Md

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10070

10028 **CERTIFICATE OF DEATH** Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beverly Beach, Mayo P.O.
STREET ADDRESS (If rural, give location) 213 Spruce Street

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Elizabeth Waters Stevens

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 30th. 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow

8. DATE OF BIRTH: 1/3/1873

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Melsville, Minn.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Waters

14. MOTHER'S MAIDEN NAME: Sarah Maguire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. H. E. Bathwick ; Mayo, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Intercerebral Heart Disease — Interval Between Onset and Death: unknown

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b) Generalized Arteriosclerosis — unknown

DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Fracture surgical Reduction Left Femur — 10 days

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 19 54, to Nov. 30 54, that I last saw the deceased alive on Nov. 30 54, and that death occurred at 4:45 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Edward J. Bieh MD 4 Prathgate Ave Annapolis 11-30-54

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify): DATE THEREOF Dec 2 54 NAME OF CEMETERY OR CREMATORY Washington LOCATION (City, town, or county) (State) Washington DC

DATE REC'D BY LOCAL REG. Nov 30, 1954 REGISTRAR'S SIGNATURE H. E. Bathwick

24. FUNERAL DIRECTOR ADDRESS Jos F Birch Sons 3034 Nst NW Wash DC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10071

10070

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 27 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City
STREET ADDRESS (If rural give location) 579 W. Hoffman Street

3. NAME OF DECEASED: (Type or Print) (First) Agnes (Middle) (Last) Stewart

4. DATE OF DEATH: (Month) 11 (Day) 7 (Year) 1954

5. SEX Female | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widow | 8. DATE OF BIRTH: 1881? | 9. AGE last birthday 73? yrs. | IF UNDER 1 YEAR Months — Days — | IF UNDER 24 HRS. Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: — — — —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Henry Hackley
14. MOTHER'S MAIDEN NAME: Alice Hackley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) — — —
16. SOCIAL SECURITY NO. — — —
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (A) Chronic Myocarditis — Known to us since 10/11/54

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Generalized arteriosclerosis

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senility

19A. DATE OF OPERATION: — — — —
19B. MAJOR FINDINGS OF OPERATION — — — — — — — —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — — — —
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) — — — — — — — — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR? — — — — — — — — — — — — — —

22 I hereby certify that I attended the deceased from 10/11, 19 54 to 11/7, 19 54 that I last saw the deceased alive on 11/7, 19 54, and that death occurred at 2:15 PM, from the causes and on the date stated above.

SIGNATURE L. Benedict, M. D. M. D.
ADDRESS Crownsville, Md.
DATE SIGNED 11/7/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 11/10/1954
NAME OF CEMETERY OR CREMATORY Baltimore National Cem.
LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REGISTRAR 11-9-54
REGISTRAR'S SIGNATURE A. Ted Hedrick Jr.
24 FUNERAL DIRECTOR Kane & Williams
ADDRESS 322 N Schroeder St Baltimore Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS. A15—10-53

10029

11129
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A.A. County MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis
LENGTH OF STAY (in this place) 15 YEARS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Adams. Park.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Annapolis.
STREET ADDRESS (If rural, give location) Adams Park.

3. NAME OF DECEASED: (Type or Print) (First) Otis (Middle) Bratton (Last) Stoval.
4. DATE OF DEATH (Month) 11 (Day) 14 (Year) 1954
5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S
8. DATE OF BIRTH:
9. AGE last birthday: 46 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): MAID
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Police - Annapolis City

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Chronic hypocandistio — INTERVAL BETWEEN ONSET AND DEATH 5 yrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Chronic Alcoholism

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE C. Lenhardt M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑
DATE SIGNED 12/16/54

23. BURIAL, CREMATION, REMOVAL (Specify): Stored Embalmed
DATE THEREOF 1/3/55
NAME OF CEMETERY OR CREMATORY Union of Maryland
LOCATION (City, town, or county) (State) Md. Sch. Baltimore, Maryland
DATE RECD BY LOCAL REG. 1/5/55
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR ADDRESS The Anatomy Board of Maryland per J. M. Christie

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10072

10071 CERTIFICATE OF DEATH Reg. Dist. No. 27

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade X
LENGTH OF STAY (In this place) Unknown
HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pa. COUNTY Delaware
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havertown
STREET ADDRESS (If rural give location) 10 E. Mathart Avenue

3. NAME OF DECEASED: (Type or Print) (First) Ellen (Middle) Jane (Last) Tell

4. DATE OF DEATH: (Month) (Day) (Year) November 25 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 3 April 83

9. AGE last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Mc Dermott

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Major John A. Tell, Son, Fort G.G. Meade

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1
IMMEDIATE CAUSE (A) Coronary Artery Thrombosis — 15 Days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Arteriosclerosis — 10 Years
DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11 Nov, 1954 to 24 Nov, 1954, that I last saw the deceased alive on 24 Nov, 1954, and that death occurred at 0800 M, from the causes and on the date stated above.

SIGNATURE Delma W. Caldwell — ADDRESS — DATE SIGNED
DELMA W. CALDWELL, MAJ, MC M.D. Fort GG. Meade 25 Nov 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF 30 Nov 54 — NAME OF CEMETERY OR CREMATORY St. Dennis — LOCATION (City, town, or county) (State) Havertown Pa.

DATE REC'D BY LOCAL REGISTRAR 25 Nov 54 — REGISTRAR'S SIGNATURE T. A. GORLON, CWO, USA

24. FUNERAL DIRECTOR John Mc Conaghy — ADDRESS Ardmore, Pa.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

DL3
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10073

10072 CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade; LENGTH OF STAY (in this place) 3 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS U. S. Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY -; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural give location) 1905 W. Mosher St.

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) Theron (Last) Thomas Jr.

4. DATE OF DEATH: (Month) (Day) (Year) November 20 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single

8. DATE OF BIRTH: 19 November 1954

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months Days 1; IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Theron Thomas

14. MOTHER'S MAIDEN NAME: Nellie Marie Melton Baltimore, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: same as 14

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Prematurity with congenital atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) DUE TO Cerebral anoxia with respiratory arrest — 1 day

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc. | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 Nov, 19 54 to 20 Nov, 19 54 that I last saw the deceased alive on 20 Nov, 19 54, and that death occurred at 0700 M, from the causes and on the date stated above.

SIGNATURE Robert Moore Capt MC — ADDRESS — DATE SIGNED

ROBERT MOORE, CAPT., MC M. D. Ft GG Meade, Maryland 20 Nov 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | DATE THEREOF 23 Nov 54 | NAME OF CEMETERY OR CREMATORY Post Cemetery | LOCATION (City, town, or county) (State) Ft GG Meade, Md.

DATE REC'D BY LOCAL REGISTRAR 22 Nov 54 | REGISTRAR'S SIGNATURE T.A.GORDON, CWO, USA | 24. FUNERAL DIRECTOR ADDRESS Chaplain Wessmerman Ft Meade, Md.

Items 18&21 Film 10973 30-54 ams

10074
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince Georges
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	LENGTH OF STAY (In this place) Transient
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Upper Marlboro	
HOSPITAL OR INSTITUTION OR STREET ADDRESS South River Club Road	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
GUY	E.	Tippett	Nov. 16 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	May 13, 1913	41 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Tobacco Farmer	Tenent	Maryland.	U. S. A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Samuel B. Tippett	Ethel (nee Smith)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Mrs. Ethel Tippett Lothian, Maryland.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Shotgun wound of neck	
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
		South Race Club Rd. A.A. Md.

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 11-16-54 P.M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
		Firearms

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Emil F. Meyer M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED 11/17/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/20/54	Mt. Carmel Cemetery	Upper Marlboro, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
11/23/54	De Alba	Ritchie Bros. Upper Marlboro, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10075

10074 CERTIFICATE OF DEATH

Reg. Dist. No. 1-11

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville
LENGTH OF STAY (in this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural give location) 2040 Ruxton Avenue

3. NAME OF DECEASED: (First) LILLIAN (Middle) (Last) TOLLIVER
4. DATE OF DEATH: (Month) 11 (Day) 3 (Year) 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	Negro	Single	April 15, 1900	54? yrs.	—	—	—	—

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	Pvt Family	Shepherdstown W. Va.	

13. FATHER'S NAME: James M. Tolliver
14. MOTHER'S MAIDEN NAME: Hester Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:
Unk.	Unk.	Unk.	Hospital Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

300.7 IMMEDIATE CAUSE (A) Respiratory failure

ANTECEDENT CAUSE (S) DUE TO (B) Schizophrenic reaction, catatonic — 10/20/54

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dehydration, malnutrition

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
— — — —	— — — — — — — —	YES ☑ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
	— — — — — —	— — — — — —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While at work ☐ Not while at work ☐	21F. HOW DID INJURY OCCUR?
— — — — — M.		— — — — — — — — — — — —

22. I hereby certify that I attended the deceased from 10/20/, 1954, to 11/3/, 1954, that I last saw the deceased alive on 11/3/54 19 ..., and that death occurred at 10 P M, from the causes and on the date stated above.

SIGNATURE C E Hubach M. D. ADDRESS Crownsville State Hosp DATE SIGNED 11/3/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov 1954	Arlington Mem. Pk.	Balto Co. Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11-5-54	[illegible]	Holland Funeral Home	Druid Hill Ave.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

10075 MARYLAND STATE DEPARTMENT OF HEALTH 10076

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Davidsonville Manor — LENGTH OF STAY (In this place) 5 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Richie Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 189 - Duvall Crescent

3. NAME OF DECEASED (Type or Print): (First) MARY-VANDELI (Middle) VUCASSOVICH. (Last)

4. DATE OF DEATH: (Month) 11 (Day) 18 (Year) 54

5. SEX: F. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced | 8. DATE OF BIRTH: Unknown | 9. AGE Last birthday: About 65 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home | 10b. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): Chicago Ill | 12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT AND ADDRESS: (Attorney) R. P. Melvin Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — Sudden

Antecedent cause (a) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral Arteriosclerosis — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Rudolf A. Famiglietti M.D. Resident Annapolis, Md/Surgeon Md 11/18/54

CREMATION ~~BURIAL~~ (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

11-20-54 | Ft Lincoln | Bmore Co Md

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS

Nov. 19, 1954 | J. C. Durnell | John M Taylor Sons | Annapolis Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10077

10076 CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade
LENGTH OF STAY (in this place) 8 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS US Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Illinois COUNTY Williamson
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Herrin
STREET ADDRESS (If rural give location) 513 N. 21st St.

3. NAME OF DECEASED: (Type or Print) (First) Lonnie (Middle) Dale (Last) Warren

4. DATE OF DEATH: (Month) November (Day) 15 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): -

8. DATE OF BIRTH: 30 Nov 52

9. AGE last birthday: 1 yrs. IF UNDER 1 YEAR: Months 11 Days 15 IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Herrin, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Brail Leonard Warren

14. MOTHER'S MAIDEN NAME: Rosalee McNew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) -

16. SOCIAL SECURITY NO. None

17. INFORMANT & ADDRESS: Father

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Neuroblastoma involving liver and lungs — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 0610 15 Nov 1954 to 1400 15 Nov 1954 that I last saw the deceased alive on 15 Nov 1954 and that death occurred at 1400 M, from the causes and on the date stated above.

SIGNATURE Robert Moore Capt MC — ADDRESS — DATE SIGNED

ROBERT MOORE, CAPT, MC M. D. Ft Meade, Md. 15 Nov 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Unknown — NAME OF CEMETERY OR CREMATORY Carterville Cemetery — LOCATION (City, town, or county) Carterville (State) Illinois

DATE REC'D BY LOCAL REGISTRAR 15 Nov 54 — REGISTRAR'S SIGNATURE T. A. GORDON, CWO, USA

24. FUNERAL DIRECTOR Reggins Funeral Home — ADDRESS Carterville, Ill.

TWO FOR ONE CERTIFICATE FILM G174 - 12/3/54 mmb

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10078

10077 **CERTIFICATE OF DEATH** Reg. Dist. No. 22

1. PLACE OF DEATH:
COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Odenton
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Odenton
STREET ADDRESS (If rural give location) X

3. NAME OF DECEASED: (Type or Print) (First) Isaiah (Middle) (Last) Wilson

4. DATE OF DEATH: (Month) Nov., (Day) 8, (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: May 6, 1885

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months 6 Days 2 IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Employer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Conway, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Wilson

14. MOTHER'S MAIDEN NAME: Ella J. Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 717-07-6565

17. INFORMANT & ADDRESS: Anna Wilson, Odenton, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE (A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

ANTECEDENT CAUSE (B) DUE TO Hypertensive Cardio-Vascular Disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 0

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/ 15, 1954, to 11/8, 1954, that I last saw the deceased alive on ....., 19..., and that death occurred at ..... M, from the causes and on the date stated above.

SIGNATURE Theodore A. Johnson M.D. M.D. ADDRESS 37 Calvert Street DATE SIGNED 11/8/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Nov., 11, 1954 — NAME OF CEMETERY OR CREMATORY Forks — LOCATION (City, town, or county) (State) Odenton, Md.

DATE REC'D BY LOCAL REGISTRAR Nov. 12, 1954 — REGISTRAR'S SIGNATURE Dana Kuehl

24. FUNERAL DIRECTOR J.B. Johnson — ADDRESS Annapolis, Md.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 24 1954
BUREAU V. S.

10079

MARYLAND Rose Zide (Deceased)

STATE DEPARTMETT OF HEALTH

10030 CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, — LENGTH OF STAY (in this place) 10
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital 10

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis 10
STREET ADDRESS (If rural, give location) Truxton Hgts

3. NAME OF DECEASED (Type or Print): (First) ROSE (Middle) (Last) ZIDE

4. DATE OF DEATH (Month) (Day) (Year): NOVEMBER 19, 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced

8. DATE OF BIRTH: Unknown

9. AGE last birthday: 65 yrs. — If under 1 year: Months. Days. — If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): St. Lawrence, N.D.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknonw

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ---
(If year, give war or dates of service): ---

16. SOCIAL SECURITY NO.: -----

17. INFORMANT AND ADDRESS: Mr. John Zide- Son - Same as # 2

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

540.1

Immediate cause (a) Generalized Peritonitis — 40 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Perforated Gastric Ulcer — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease with Coronary Insufficiency; Nephrosclerosis; Hypertension

19a. DATE OF OPERATION: 2

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-4, 1954, to 11-19, 1954, that I last saw the deceased alive on 11-19-54, 1954, and that death occurred at 3:40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Edward S Beck MD — 4 Southgate Ave Annapolis — 11-19-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE 11-22-54 — NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Cemet — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Nov. 22, 1954 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: Ben L. Hopping and Son — Annapolis, Md.

RECEIVED
JUN 29 1934
BUREAU V. S.